BRUNSWICK COUNTY HEALTH SERVICES PFIZER COVID-19 VACCINE CONSENT FORM

	Name:Date of Birth			
_	Address:			
	imber to reach you at if we need to call you during your child's visit:	_		
-	Number:Mobile Phone Number:			
	City:			
Zip Code:	County:Stat	e:		
Race:	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American			
	☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unkn	own		
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	0 111		
•	☐ Male ☐ Female ☐ Other ☐ I do not want to specify			
	- · ·			
Preferred Lai				
D. 1	☐ Spanish ☐ Hindi ☐ Other ☐ Declin			
Disabilities:	☐ Not Disabled ☐ Cancer ☐ Cognitive (Psychological Cognitive)	_	sychiatri	ic)
	☐ Neurological ☐ Physical (Mobility) ☐ Respirator	y		
	☐ Sensory (Vision or Hearing) ☐ Other (Please Specify:)
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